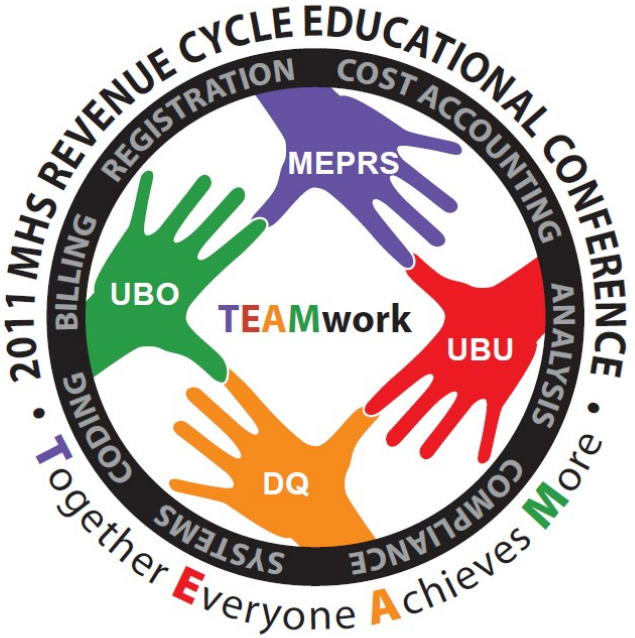

Title: **How to Interpret an EOB**

Session: **R-1-1000**

Objectives

- Learn how to read and understand an Explanation of Benefits (EOB)
- Recognize invalid denials
- Learn to communicate effectively with insurance carriers and payers
- Develop a plan

Sample EOB

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https://www.premera.com/stellent/groups/public/documents/pdfs/016548.pdf

EXPLANATION OF BENEFITS

Dec 01, 2005

SAMPLE

Group Number:	12345678
Member:	John Sample
Member's ID:	10000017-01
Claim Number:	8000000001
Provider:	Smith, Robert
Payment Reference ID:	2002062510100013

(This Is NOT a bill)

1 Service/ product description	2 Dates you received service/product (m/d/y to m/d/y)	3 Charges billed by provider	4 Minus provider's fee adjustment (*)	5 Minus your copay (C), deductible (D) or amount not covered (**)		6 Total amount eligible for benefits	7 %	8 Minus your coinsurance amount	9 Plus or (minus) adjustment	10 Total paid by your plan	11 Amount you're responsible for
OFFICE VISIT	11/15/05 11/15/05	75.00	12.00 PDC	15.00	C	48.00	100%			48.00	15.00
LAB	11/15/05 11/15/05	89.12	15.36 PDC	50.00	D	23.76	100%			23.76	50.00
X-RAY	11/15/05 11/15/05	100.00	20.00 PDC			80.00	80%	16.00		64.00	16.00
SURGERY	11/15/05 11/15/05	50.00		50.00	575	0	0%			0.00	50.00
Totals		$314.12	$47.36	$115.00		$151.76		$16.00		$135.76	$131.00

Amount you're responsible for: $131.00

Your 2005/Plan Year Medical Deductible satisfied so far: $100.00
Your 2005 Plan Year Family Medical deductible satisfied so far: $300.00
Amount you're responsible for: $131.00

Message Codes:
PDC AGREEMENT DISCOUNT
575 THIS PROCEDURE IS CONSIDERED COSMETIC. YOUR PLAN DOESN'T COVER COSMETIC SERVICES.
Z48 NOTE: WHEN YOU RECEIVE SERVICES FROM A NON-PREFERRED PROVIDER, WE MAY PAY BENEFITS DIRECTLY TO YOU. IF SO, YOU WILL NEED TO MAKE ARRANGEMENTS TO REIMBURSE THE PROVIDER.
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AlaskaCare Health Plans

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

Sample EOB (Continued)

Definitions of terms on your EOB. The **blue** numbers on the sample EOB refer to the definitions below.

1. **Service/product description**—what you received from your provider
2. **Dates you received service/product**—when you saw your provider (month/day/year to month/day/year)
3. **Charges billed by provider**—amount billed to you and your health-care plan(s)
4. **Provider's fee adjustment**—difference percentage. between "charges billed by provider" and the amount providers have agreed to accept as full payment; see "Message Codes" at the bottom of your EOB for details

Sample EOB (Continued)

5. **Your copay, deductible, or amount not covered**—"copay" is a set fee you pay amount." a provider at each visit; "deductible" is how much you pay each year before your benefits start; "amount not covered" applies to services/products not covered by your plan; see "Message Codes" at the bottom of your EOB for details
6. **Total amount eligible for benefits**—"charges billed by provider" minus "provider fee adjustment" minus "your copay, deductible or amount not covered"
7. **%**—percentage level of benefits for covered services/products
8. **Your coinsurance amount**—what you must pay the provider after we pay the covered percentage

Sample EOB (Continued)

9. **Adjustment**—see explanation(s) at the bottom of your EOB for details
10. **Total paid by your plan**—"total amount eligible for benefits" minus "your coinsurance amount"
11. **Amount you're responsible for**—what you must pay of the billed charges after your plan benefits are paid

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Recognize Invalid Denials

- Non-participating provider
- Medicare EOB required
- Incorrect data
  - Cause payer denials
  - Cause claim rejections
  - Cause slow down in payment
  - Cause payers to question credibility of future claims
- Procedure or service not medically necessary

Recognize Invalid Denials (Continued)

- Pre-existing condition
- Non-covered benefit
- Termination of coverage
- Failure to obtain preauthorization
- Out-of-network provider used
- Lower level of care could have been provided
- Lost claims
- Missing information
- Timely filing

Common Errors

- Incorrect patient identification code
- Incomplete or incorrect dates of service
- Missing plan code or group number
- Wrong or missing revenue code Plans only pay benefits for a valid ID number
- Month, date and year are required
- Some plans require a plan code or group number

Common Errors (Continued)

- Plans require correct revenue codes
- Plans require correct occurrence codes
- Plans accept two digits or two letters; each plan has different preferences
- Missing occurrence code
- Incorrect or missing place of service

Communicate with Payer Representative

- Read the EOB carefully
- Call the carrier if a denial reason needs clarification
- Consider that the denial could be used for contract providers, which doesn't apply to the MTF
- Get specific directions about where to send the appeal and what documents are required
- If the carrier maintains the denial, forward to base Legal

Provider Relations

- Get to know your Provider Representative's name
- Review with them where they are not compliant
- Determine what is causing the problem resulting in errors or rejections
- Determine if you can alter these items – Wrong NCPDP, no Provider # while on the phone with them
- Payers or PBMs not paying claims without a Medicare EOB

DoD Regulations

- 32 CFR 220.3: “The lack of participation or the absence of a contract is not grounds to deny or reduce payment to an MTF”
- 32 CFR 220.4: “Such provisions are not permissible if they are applied in a manner that would result in claims arising from services provided by or through facilities of the Uniformed Services being treated less favorably than claims arising from services provided by other hospitals or providers”
- 32 CFR 220.14: “All carriers, including PPO, HMO, EPO, Self-Insured, ERISA and Workers Comp plans are subject to both the US Code and the Code of Federal Regulations”

Conclusion

- Remember to use the correct DoD regulations on all your correspondence – 10 USC 1095 and 32 CFR 220
- Documentation is very important
- Always escalate your call to a manager, especially when an appeal may involve a large quantity of claims
- Be patient and have a strategic plan
- Make sure your claims are “clean” before you send them out
- Helpful Web sites:
  - http://www.tricare.mil//ocfo/mcfs/ubo/index.cfm
  - e-CFR Web site: www.ecfr.gpoaccess.gov
  - UBO Helpdesk@altarum.org